BORINQUEN MEDICAL CENTERS

INFLUENZA IMMUNIZATION CONSENT FORM

NAME: _____ D.O.B:_____

ATHENA MR#_____

Please read through and complete questionnaire, discuss with the nurse if you do not understand the questions.

1. Have you ever had a bad reaction to any previous vaccines? Yes_____ No _____
2. Are you unwell today with an illness associated with a fever? Yes _____ No _____
3. Have you had a severe allergic reaction (shock, collapse, rash, wheezing) to eggs or chicken feathers, neomycin, polymycin, and gentamycin or a previous influenza vaccine? Yes _____ No _____
4. Have you suffered from guillian barre syndrome in the past? Yes _____ No _____
5. Are you in agreement with the administration of an influenza vaccination to be given by the Nurse? Yes _____ No _____

POSSIBLE ADVERSE EVENTS AND PRECAUTIONS

- The influenza vaccine is generally well tolerated.
- Occasional discomfort, redness and swelling at the injection site is the most common adverse reaction.
- Fever, muscle pain and generally feeling unwell occur infrequently within a few hours of vaccination and may last 1-2 days.
- Immediate adverse events such as hives, angio-edema, and asthma or systemic anaphylaxis are a rare consequence of vaccination.
- I have read and understand this information and consent to receive an influenza vaccine injection.
- I understand I will need to wait at the immunization center for 10-15 minutes after the vaccination.

Signature:_____ Date:_____

FOR OFFICE USE ONLY

Influenza vaccine given by:_____ Date:_____

Signature: _____